AMENDED IN SENATE APRIL 19, 2005

AMENDED IN SENATE MARCH 31, 2005

SENATE BILL No. 367

Introduced by Senator Speier

February 17, 2005

~~An act to amend Section 1368.02 of the Health and Safety Code, and~~ *An act* to amend Sections ~~510,~~ *10123.147,* 12921, 12921.1, 12921.15, 12921.3, and 12921.4 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 367, as amended, Speier. Health care complaint system.

Existing law~~, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (DMHC). Existing law also~~ provides for the ~~licensure~~ *licensure* and regulation of health ~~insurance~~ *insurers* by the Department of Insurance *and requires the Insurance Commissioner to establish a program to investigate and respond to complaints concerning insurers. Under existing law, a health insurer is required to reimburse a provider's complete claim within a specified timeframe or to provide a notice to the provider explaining its reasons for denying or contesting the claim*.

This bill would ~~require the director of the DMHC to contract with the Insurance Commissioner for the DMHC to receive complaints regarding health insurers. The bill would specify that unresolved inquiries and complaints would be forwarded to the commissioner for processing and resolution and would~~ require the commissioner before July 1, 2006, to ~~establish a unit to resolve~~ *include within the complaint program, an Internet Web site dedicated exclusively to processing* complaints relating to health insurers *and providing information*

concerning the process for filing complaints and making inquiries concerning health insurers. The bill would require the commissioner to make a determination on a complaint within 30 days, except as specified. The bill would also require a health insurer to provide a copy of its notice denying or contesting a provider's claim to each insured who received services pursuant to that particular claim and to include a statement within that notice that the provider or insured may request review by the department of the insurer's action.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares the following:

(1) Health care services must be available to Californians without unnecessary administrative procedures, interruptions, or delays.

(2) As of May 2002, the Department of Insurance estimated that it regulated insurers covering 28.79 percent of the total accident and health care market and that, with respect to those commercial products that are comparable between the Department of Insurance and the Department of Managed Health Care regulated products, the Department of Insurance regulated 16.8 percent of the comprehensive commercial health insurance provided to Californians.

(3) With two separate departments responsible for regulating entities that provide health care coverage, patients and their health care providers are often confused about the identity of the ~~appropriate regulator and may be regularly referred between the departments~~ *appropriate regulator*. Further, *health care providers for* patients enrolled in insurance products regulated by the Department of Insurance~~ and their health care providers do not have a dedicated unit within the Department of Insurance that has been designated to resolve health coverage complaints.~~ *are unable to complain to that department about their payment disputes with health insurers subject to the department's jurisdiction.*

(b) It is the intent of the Legislature to reduce confusion about the identity of the appropriate regulator, to provide all patients

who have health care coverage and their health care providers ~~with a single entity that is visible, easily accessible, and able to~~ *with an easy and effective mechanism within the Department of Insurance to* effectively resolve complaints, and to assure the public that the law is properly implemented.

SEC. 2. This act shall be known and may be cited as the Patient and Provider Preferred Provider Organization Protection Act.

~~SEC. 3. Section 1368.02 of the Health and Safety Code is amended to read:~~

~~1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving and, if appropriate, resolving complaints regarding health care service plans regulated by the director. The director shall also contract with the Insurance Commissioner for the department to receive complaints regarding health insurers regulated by the commissioner. The director may respond to an initial inquiry concerning a health insurer, but shall forward all unresolved inquiries and complaints concerning a health insurer to the commissioner for processing and resolution. The purpose of the contract is to establish a single point where all persons who have health care coverage and their providers, can make health coverage complaints. Nothing in the contract shall be construed to provide the director with regulatory authority over health insurers.~~

~~(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:~~

~~"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."~~

~~(c) (1) There is within the department an Office of Patient Advocate, which shall be known and may be cited as the Gallegos-Rosenthal Patient Advocate Program, to represent the interests of enrollees served by health care service plans regulated by the department. The goal of the office shall be to help enrollees secure health care services to which they are entitled under the laws administered by the department.~~

~~(2) The office shall be headed by a patient advocate recommended to the Governor by the Secretary of the Business, Transportation and Housing Agency. The patient advocate shall be appointed by and serve at the pleasure of the Governor.~~

~~(3) The duties of the office shall be determined by the secretary, in consultation with the director, and shall include, but not be limited to:~~

~~(A) Developing educational and informational guides for consumers describing enrollee rights and responsibilities, and informing enrollees on effective ways to exercise their rights to secure health care services. The guides shall be easy to read and~~

~~understand, available in English and other languages, and shall be made available to the public by the department, including access on the department's Internet Web site and through public outreach and educational programs.~~

~~(B) Compiling an annual publication, to be made available on the department's Internet Web site, of a quality of care report card, including, but not limited to, health care service plans.~~

~~(C) Rendering advice and assistance to enrollees regarding procedures, rights, and responsibilities related to the use of health care service plan grievance systems, the department's system for reviewing unresolved grievances, and the independent review process.~~

~~(D) Making referrals within the department regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of enrollees.~~

~~(E) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsperson programs.~~

~~(4) The director, in consultation with the patient advocate, shall provide for the assignment of personnel to the office. The department may employ or contract with experts when necessary to carry out functions of the office. The annual budget for the office shall be separately identified in the annual budget request of the department.~~

~~(5) The office shall have access to department records including, but not limited to, information related to health care service plan audits, surveys, and enrollee grievances. The department shall assist the office in compelling the production and disclosure of any information the office deems necessary to perform its duties, from entities regulated by the department, if the information is determined by the department's legal counsel to be subject, under existing law, to production or disclosure to the department.~~

~~(6) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.~~

~~SEC. 4. Section 510 of the Insurance Code is amended to read:~~

~~510. Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, a policy of health insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, and toll-free telephone number of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The certificate of coverage for a policy of health insurance shall also include in the disclosure the name, address, toll-free telephone number, and Internet Web site of the health care coverage complaint center established pursuant to subdivision (a) of Section 1368.02 of the Health and Safety Code. The disclosure shall be printed in large, boldface type.~~

~~The disclosure shall contain, at the discretion of the insurer, either the address and telephone number of the insurer or the address and telephone number of the agent or broker of record, or both of those addresses and telephone numbers. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.~~

SEC. 3. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (a) Every insurer issuing group or individual policies of ~~disability~~ *health* insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is

contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial*, including the factual and legal basis for each reason. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied. The notice required by this subdivision shall include a statement advising the provider and the insured that either may seek review by the department of a claim that was improperly contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function.* An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and

reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer

shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

~~SEC. 5.~~

SEC. 4. Section 12921 of the Insurance Code is amended to read:

12921. (a) The commissioner shall perform all duties imposed upon him or her by the provisions of this code and other laws regulating the business of insurance in this state, and shall enforce the execution of those provisions and laws.

(b) In an administrative action to enforce the provisions of this code and other laws regulating the business of insurance in this state, any settlement is subject to all of the following:

(1) The commissioner may delegate the power to negotiate the terms and conditions of a settlement but the commissioner may not delegate the power to approve the settlement.

(2) Unless specifically provided for in a provision of this code, the commissioner may not agree to any of the following:

(A) That the respondent contribute, deposit, or transfer any moneys or other resources to a nonprofit entity.

(B) That a respondent contribute, deposit, or transfer any fine, penalty, assessment, cost, or fee except to the commissioner for deposit in the appropriate state fund pursuant to Section 12975.7.

(C) That the commissioner may or shall direct the transfer, distribution, or payment to another person or entity of any fine, penalty, assessment, cost, or fee.

(D) The use of the commissioner's name, likeness, or voice in any printed material or audio or visual medium, either for general distribution or for distribution to specific recipients.

(3) The commissioner may only agree to payment to those persons or entities, including a provider authorized to receive reimbursement directly from the insurer pursuant to Section 10133, to whom payment may be due because of the respondent's violation of a provision of this code or other law regulating the business of insurance in this state.

(4) A settlement may only include the sanctions provided by this code or other laws regulating the business of insurance in this state, except that the settlement may include attorney's fees, costs of the department in bringing the enforcement action, and future costs of the department to ensure compliance with the settlement agreement.

~~SEC. 6.~~

SEC. 5. Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers. The program shall include, but not be limited to, the following:

~~(1) Contracting with the Department of Managed Health Care to authorize that department to receive complaints and inquiries regarding health insurers regulated by the commissioner, as described in subdivision (a) of Section 1368.02 of the Health and Safety Code.~~

~~(2)~~

(1) Toll-free telephone numbers published in telephone books throughout the state *and on the commissioner's Internet Web site*, dedicated to the handling of complaints and ~~inquiries, including those received by the complaint center established pursuant to subdivision (a) of Section 1368.02 of the Health and Safety Code.~~

~~(3)~~ *inquiries.*

(2) Public service announcements to inform consumers *and their health care providers* of the toll-free telephone number *and the Internet Web site* and how to register a complaint or make an inquiry to the department.

~~(4)~~

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

~~(5)~~

(4) Retention of records on complaints for at least three years after the complaint has been closed.

~~(6) A separate unit~~

(5) An Internet Web site address dedicated exclusively to processing complaints and inquiries *from insureds and their health care providers* relating to health insurance. The~~ unit~~ *Internet Web site* shall provide insureds and their health care providers with~~ an easy and efficient method to resolve complaints and inquiries~~ *information concerning filing a complaint and making an inquiry concerning a health insurer* and, at a minimum, shall~~ comply with~~ *provide* the following ~~requirements:~~

~~(A) Conspicuously place information on its Internet Web site about the unit, including its toll-free telephone number and e-mail address, and that identifies all insurers licensed by the department that offer health insurance.~~

~~(B) Develop educational~~ *information:*

(A) The department's toll-free telephone number.

(B) A list of all insurers licensed by the department that offer health insurance.

(C) Educational and informational guides for insureds and health care providers describing their rights under this article. The guides shall be easy to read and understand and shall be made available to the public, including access on the department's Internet Web site.

~~(C) Provide a~~

(D) A separate, standardized complaint form for insureds and health care providers to file a complaint.

~~(7)~~

(6) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to those that are found to be without merit. This information shall be disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

~~(8)~~

(7) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers.

~~(9)~~

(8) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

~~(10)~~

(9) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

~~(11)~~

(10) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

~~(12)~~

(11) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to complaints if further enforcement is deemed necessary to insure proper compliance by insurers with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer.

(c) The commissioner shall provide to the insurer a description of any complaint against the insurer that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

(1) The name of the complainant.

(2) The date the complaint was filed.

(3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

(f) The commissioner shall complete the requirements imposed by the amendments to subdivision (a) made by Senate Bill No. 367 of the 2005-06 Regular Session before July 1, 2006. ~~Nothing in this section shall be construed to provide the Department of Managed Health Care with regulatory authority over health insurers.~~

~~SEC. 7.~~

SEC. 6. Section 12921.15 of the Insurance Code is amended to read:

12921.15. On an annual basis, the commissioner shall prepare a written report, to be made available by the department to interested individuals upon written request, that details complaint and enforcement information on individual insurers in accordance with guidelines established under ~~paragraphs (6) and (7)~~ *paragraph (6)* of subdivision (a) of Section 12921.1. The report shall be made available by mail through the department's consumer toll-free telephone number and through the department's Internet Web site and transmitted via electronic mail if the individual has the ability to obtain the report in this manner. No complaint information shall be included in the report required by this section that has not been provided to the insurer in accordance with subdivision (c) of Section 12921.1.

~~SEC. 8.~~

SEC. 7. Section 12921.3 of the Insurance Code is amended to read:

12921.3. (a) The commissioner, in person or through employees of the department, shall receive complaints and inquiries, investigate complaints, prosecute insurers when appropriate and according to guidelines determined pursuant to Section 12921.1, and respond to complaints and inquiries by

members of the public concerning the handling of insurance claims, including, but not limited to, violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1, by insurers, or alleged misconduct by insurers or production agencies.

(b) The commissioner shall not decline to investigate ~~complaints or to take enforcement action as a result of a complaint~~ *complaints* for any of the following reasons:

(1) The insured is represented by an attorney in a dispute with an insurer, or is in mediation or arbitration.

(2) The insured has a civil action against an insurer.

(3) The complaint is from an attorney, if the complaint is based upon evidence or reasonable beliefs about violations of law known to an attorney because of a civil action.

~~(4) The complaint is based on a single violation of law and not on a pattern of unlawful conduct.~~

(c) The commissioner may defer the investigation until the finality of a dispute, mediation, arbitration, or civil action involving the claim is known.

(d) The commissioner, as he or she deems appropriate, and pursuant to Section 12921.1, shall provide for the education of, and dissemination of information to, members of the general public or licensees of the department concerning insurance matters.

(e) The commissioner may take enforcement action based on a single violation of law.

~~SEC. 9.~~

SEC. 8. Section 12921.4 of the Insurance Code is amended to read:

12921.4. (a) (1) The commissioner shall, upon receipt of a written complaint with respect to the handling of an insurance claim or other obligation under a policy by an insurer or production agency, or alleged misconduct by an insurer or production agency, notify the complainant of the receipt of the complaint within 10 working days of receipt. ~~Thereafter~~ *If the complaint involves a policy of health insurance*, the commissioner shall make a determination on the complaint within ~~60~~ *30* days of the date of its receipt. ~~This timeframe may be extended by the commissioner by detailing in writing to the complainant, the facts showing good cause for extending the~~

~~timeframe within which to decide the complaint.~~*, unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the complaint.*

(2) ~~The~~ *With respect to all complaints, the* commissioner shall notify the complainant of the final action taken on his or her complaint within 30 days of the final action. *If a complaint involves health insurance, the notification shall include a summary of the commissioner's findings and the reasons for the commissioner's determination that the health insurer complied or failed to comply with the applicable laws, regulations, or orders of the commissioner.* The department shall include, with each notification of final action, or, at a minimum, with a number of randomly selected notifications of final action sufficient to assure the validity of results, a complaint handling evaluation form. This form shall clearly and concisely seek an evaluation of the department's performance in handling the complainant's grievance. The areas of evaluation shall include, but not be limited to*,* the following:

~~(1)~~

(A) Whether the complaint was handled in a fair and reasonable manner and evaluated thoroughly and without bias.

~~(2)~~

(B) The time required for resolution of the complaint.

~~(3)~~

(C) Whether the complaint was referred and, if so, whether it was referred within a satisfactory time.

~~(4)~~

(D) Whether the staff involved in handling the complaint demonstrated an adequate knowledge of the issues involved in the complaint.

~~(5)~~

(E) Whether the complainant was satisfied with the result of the department's intervention.

~~(6)~~

(F) Whether the complainant would recommend the department's complaint handling services to others.

(b) The commissioner shall, if deemed appropriate, notify insurers or production agencies against whom the complaint is made of the nature of the complaint, may request appropriate

relief for the complainant, and may meet and confer with the complainant and the insurer in order to mediate the complaint. This section shall not be construed to give the commissioner power to adjudicate claims.

(c) The commissioner shall ascertain patterns of complaints by insurer, geographic area, insurance line, type of violation, and any other valid basis the commissioner may deem appropriate for further investigation, and periodically evaluate the complaint patterns to determine additional audit, investigative, or enforcement actions which may be taken by the commissioner, and report on all actions taken with respect to those patterns of complaints in his or her annual report to the Governor pursuant to Section 12922, and to the public. For the purposes of this subdivision, complaints mean those written complaints received by the commissioner under subdivision (a), and written complaints received by the commissioner from any other sources, alleging misconduct or unlawful acts by insurers or production agencies.

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